INFORMATION

Something for Nothing?

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THE "APPOINTED DAY" for the starting of the National Health Service in England was July 5, 1948. The Minister of Health, Mr. Aneurin Bevan, was responsible to Parliament for seeing that health services of all kinds are available to all who need them. Two plebiscites were called by the British Medical Association before the act was passed. The result of the first showed 90 per cent of the physicians against the proposed act. A few months later a second vote was taken after certain amendments were made, and the medical profession was split 50-50.

One of the reasons it passed so easily was that the people were conditioned for legislation of this type after the many controls and hardships during the war. Sir Allen Daley, head of the London County Council, said the National Health Service was inevitable, because both parties promised it in some form; but had organized medicine presented a united front many of the abuses could have been avoided—and the results different.

Shortly after the act was passed the British Medical Association asked for a meeting with Mr. Bevan in an endeavor to work out the details. Mr. Bevan agreed, and after keeping representatives of the association waiting more than an hour finally appeared and at once subjected the physicians to forty minutes of abuse and insults, stating "I'm not here to waste my time listening to what you doctors want; I'm here to tell you how you're going to practice under the act and what you are going to get."

Medicine was an adjunct of the socialist government of Great Britain for four years. What has that experiment to show us? How has the theoretical blueprint worked out in practice? Are conditions in the United States so closely parallel to those in Great Britain in 1947 that the same radical changes are needed here and now as were adopted then and there? Shall we rush to follow our neighbor's example? Or would it not be better to examine the factual details of this momentous program—and perhaps learn something from our neighbor's mistakes?

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Originally completed in 1951 and recently brought up to date, this article was written by an expert in hospital administration. It states the pitfalls and fallacies of the National Health Service in England so well that it is published for the information of our readers.

With these questions in mind I visited England in 1950. I was not concerned with political theory as such. I wanted to know what direct effects socialist theory, applied to medicine, had had on the medical profession, particularly on hospitals, but even more on that larger and equally interested group which the medical profession serves, the actual and potential patients—in short, the public. I interviewed individuals at all social, economic and vocational levels: workers, foremen, and managers in factories; bank clerks, hospital personnel, attorneys, social welfare workers; general physicians and Harley Street specialists; the head of the dental association, the supervisors of medical schools, officials in the Ministry of Health.

The gigantic program of "political medicine," I found, appeals to one of the most common urges of human nature—the desire to get something for nothing. But that is an appeal that is never really answered; there is always a catch in it. When you try to get something for nothing, you always lose something in the scramble.

The first loss to Great Britain is the virtual liquidation of the general practitioner— of the fine old tradition of the "family doctor" who knows you as a person, not a statistic or a chart record, whom you trust to "see you through."

In Great Britain, the office of the general practitioner has been reduced to a mere clearing house and place for the care of trivial ailments in metropolitan areas. Under the National Health Service he cannot operate or administer treatment in many of the state-controlled hospitals. Some hospitals refuse to allow him inside the door. Others will admit him only when trailing in the wake of a consultant or specialist; for every person requiring hospitalization is referred to a staff member who must be a specialist.

Many patients do require the treatment of a specialist. At the other extreme, a far larger number need only a word of advice and directions for home treatment. As one Middlesex doctor put it: "For every cut, burn, blister, bruise, boil, sore or small abscess, or other trivial injury that becomes serious, there are thousands that respond to home treatment with the help of nature. Crowded waiting rooms and surgeries such as I never had before July 8, 1948, even during epidemics," he continued, "are filled with women and children almost exclusively, and their complaints are for the most part picayune. During the past week I have been consulted by a daily average of 49 women, 23 children, and 8 men. In a large industrial practice usually with approximately equal numbers of both sexes on my list, those figures speak for themselves."

In other words, the chance to get something for nothing by universal "free" medical service brings

on a stampede, even when the service is not necessary. The effect on the quality of that service is obvious. Doctors are overwhelmed almost to distraction, and hospitals are overcrowded beyond all hope of efficiency. The really sick patient cannot be adequately cared for.

The doctors let themselves in for this state of affairs largely because they did not fully foresee what they were getting into, and those who did lacked the organization necessary to present and give effective power to their knowledge.

Now the British Medical Association reports that 75 per cent of the general practitioners—the backbone of the medical profession — wish the clock could be turned back. The 25 per cent in favor of the new system are young men just starting out in practice. There are 8,000 doctors in the Medical Practitioners Union—a frankly Socialist organization. Many general practitioners (not Socialist) like the National Health Service system—probably the poorer ones who want an easy life with a fixed salary, social security benefits, tenure of service, and a pension at age 65. For this they are willing to forego the longer, more exacting road with its challenge to individual effort.

According to an eminent practicing surgeon, "The general practitioner is no longer interested in doing his fair share of the work. Oddly, medical men figure largely on Group Management and Regional Management committees. These medical men with political aspirations and/or leanings are about the worst feature of the National Health Service. If you want to see medical men mishandled, put their own kind in the box seat!"

The specialists on full time basis in hospitals—for example, radiologists, pathologists and anesthesiologists—do not fare so badly. They begin at a stipend of $5,100 a year with an annual increase of $350 up to $7,700—and this income, the doctors told me, goes twice as far in Great Britain as it would in the United States. They are also eligible for annual merit awards as a non-financial incentive.

At the opposite extreme, the young doctor, just admitted to practice, may welcome the security of an assured income. However, the program was not designed for the benefit of members of the medical profession—who like it less the more they see of it—but supposedly for the general public.

The worst feature of the unnatural union of medicine and politics is the involvement of both patient and doctor in Gordian knots of red tape. The doctor is subordinated to the bureaucrat, and the art and science of medicine is reduced to an instrument of politics. Such an arrangement is not only bound to be cumbersome and inefficient, and, through the delays of all political routine, even dangerous—it also opens wide the doors to petty racketeering and tax dodging by the unscrupulous. Such charges have recently been made against dentists.

Many dentists today find that it is better to take National Health Service patients than private patients. Small profits, quick returns! Since the imposition of a charge to the patient of one pound per denture and a shilling on a bottle of medicine, there has been a vast decrease in the amount of dentistry and medication.

But even without this juggling with a system which lays itself wide open to finagling, the patient ultimately pays the price of the red tape in which both he and the doctor are entangled when medical care is made just another cog in the political machine.

One out of every 100 Britons—400,000 in all—is employed in the Ministry of Health. They may know nothing about medicine or hospital administration, but they are well trained as bureaucrats, thoroughly familiar with forms and "channels" and copies in quintuplet. The knots and tangles in which they enmesh the simplest performance are at once maddening to the doctor and dangerous to the patient.

For example, in one hospital that I visited, the cook had become ill and the superintendent had applied for a replacement. That was on January 10. First he must notify the Ministry, giving full information. Ten days later he telephoned the Ministry to ask if a cook had been found. No cook and no information. More telephoning and writing on January 23. No information. On January 25, the Ministry suggested that the superintendent advertise in the local paper—which he might better have done in the beginning. But first, the advertisement must be submitted to the Ministry for approval, and if and when it was finally run it must be labelled, "Cautionary," which means that no worker between the ages of 18 and 45 may apply for the job without the consent of the Ministry of Labor. The Ministry of Labor controls the destiny of all workers between the ages of 18 and 45. A worker may quit his job but cannot accept another without the permission of the Ministry. When I was there on January 31, there was still no cook.

If a surgeon or hospital is in urgent need of an instrument, it is not just bought so that it will be on hand for immediate use. First a detailed description of the instrument is submitted and a statement made as to whether it is to be additional equipment or is to replace another instrument. The request is passed along to a standing sub-committee, which relays it to the Medical Committee, which refers it to the Finance Committee, which sends it to the General Purpose Committee, which forwards it to the Economic Committee, which may or may not grant the request.

Even if this final report is favorable, the hospital has waited for its equipment, or the patient for his operation, for months before the order has gone its tortuous way.

On the day I visited a certain hospital, the administrator apologized for its dreary and run-down appearance—a matter of great importance to the morale of the patient, as every administrator knows. The administrator was trying to get some redecorating done, but since the law requires the approval of the Ministry for any repairs costing more than $100, he had been waiting for months for permission to repaint the hospital corridors—for the first time, incidentally, since before the war.

It is small wonder that, to American eyes, the hospital administrators of Great Britain seem inefficient and lacking in initiative. They are so trammeled in red tape, and so beset with government committees standing over them telling them how to run their hospitals—a business to which they have brought years of training and experience—that they are inclined to throw up their hands and say, "Oh, what's the use?"

The hospitals of England are badly overcrowded and understaffed. Fifty thousand hospital beds, at the time of my visit, were closed because of a shortage of trained personnel.* This is hardly surprising, since under wage fixing the maids are paid more than fourth year registered nurses. The pecuniary incentive to enter the nursing profession is small when a fourth year state registered nurse receives $674 a year, of which $281 is deducted for board, lodging, and uniforms, leaving a take-home pay of $393 a year, or approximately $33 a month.

Just as the Harley Street specialists are not affected by the National Health Service and are as busy as ever with patients who are willing to pay a private fee for expert advice, so the hospital patient can have a bed in a private ward by paying for it plus an additional 25 per cent for better food and nursing.

From this anomalous situation it is apparent that medical care under Socialism is inefficient, and that better medical care simply plays leap-frog over Socialism. You may get something for nothing, but you still get what you pay for. This, perhaps, is a notable example of the British procedure known as "muddling through." From my observation, "muddling" is indeed the word for it!

On the appointed day, July 5, 1948, the preponderance of voluntary and municipal hospitals together with their premises, equipment, furniture and other movable property were transferred to and vested in the Minister. The institutions taken over include maternity homes, tuberculosis sanatoria, infectious disease hospitals, provision for the chronic sick, mental hospitals and mental deficiency institutions, accommodations for convalescent treatment, rehabilitation, and all forms of specialized treatment.

The Minister at the same time also took over all the liabilities of these hospitals, institutions and services. In other words, he took them over as "going concerns." All the property taken over by the Minister is vested in him free of any *preexisting trust*—that is, it is at the free disposal of the Health Service.

Under the act, all endowments held by the voluntary hospitals, other than teaching hospitals, were taken over by the Minister and pooled in a Hospital Endowment Fund. The Minister is empowered to use the capital of this fund first to meet the existing debts and liabilities attaching to the voluntary hospitals, and to apportion the income received from the balance of capital among the Regional Hospital boards and Hospital Management committees.

The high-handed procedure by which hospitals for the care of the sick were taken out of the hands of trained professionals and made a cog in the political machine was nothing so blatant as straight confiscation. Operation under the National Health Service is strictly voluntary. One is irresistibly reminded of the situation in Russia, where persons conform "voluntarily"—or else.

In Great Britain, 2,000 hospitals—about 90 per cent—thus "voluntarily" allowed themselves to be taken over by the politicians and nationalized. But 244 declined to subject themselves to political medicine. Little is heard of these "disclaimed hospitals," as they are called. I was particularly interested to see how they fared and especially whether they were in any way penalized for their recalcitrance.

The "disclaimed hospitals" which declined to give up their standing and principles "voluntarily" are indeed the stepchildren of the hospital system in Great Britain. They are divided into three classes: trade union hospitals, supported by union dues; hospitals operated by religious and fraternal orders, supported by contributions and endowments; and nursing homes, which correspond to independently operated non-profit hospitals in this country. These receive no financial assistance from the socialist government. But the government has its eye on them nonetheless. With the hope of bringing them "voluntarily" into the fold, it puts every possible obstacle in the way of their successful operation. In expansion, purchase of supplies, remodeling, improvements and the promptness with which requirements are met, the "disclaimed hospitals" are discriminated against and preference given to the politically-operated, state-controlled hospitals.

*Recent information reveals that between 30,000 and 40,000 hospital beds are closed. Many of these beds are dispersed war-time beds remote from centers of population. They present great staffing difficulties in peacetime, even without a nursing shortage.

The result is an inevitable lowering of standards. The price of freedom comes high. Nevertheless, despite these severe handicaps, the independent or disclaimed hospitals are not boycotted by patients. One that I visited may be taken as an example. It has 140 beds and a personnel of 450. Although the rates are high—the average room charge is $147 a week—it is operating to capacity and has a waiting list. This hospital is supported by specialists and in it are done considerable outpatient, laboratory and x-ray work. It is hard to escape the conclusion that the value of voluntary non-profit hospitals like those in the United States is recognized even in Socialist Great Britain.

From my own informal but extensive poll of public opinion, I think there is no doubt that the people of Great Britain will not vote the system out—they have been well indoctrinated with the "something for nothing" principle. The doctors were caught napping and are now stuck with it. It is generally conceded by the medical profession that independent practice of medicine in Great Britain is doomed to extinction within the next ten years.

Has the success of political medicine in Great Britain been so striking, and is the situation in the United States in 1953 so similar to that of Great Britain in 1947, that we should rush pell mell to vote the same system into effect here?

The success of the experiment, I found from personal investigation, is, to put it mildly, far from unqualified. And the situation which brought it about is far from parallel to our own. The National Health Service Act was a policy of desperation, born of the abnormal conditions of war and the state of bankruptcy into which voluntary non-profit hospitals had fallen. Neither of these conditions applies to America today.

Moreover, the American public has been bred to different standards in the treatment of illness than those prevailing, by long custom, in England. In Britain, 70 per cent of all babies are born at home, without hospital facilities; 90 per cent are delivered by midwives with no doctor in attendance.

During the four years of political medicine, it is true that infant and maternal mortality rates in England have shown improvement. But to ascribe this improvement to political control of medicine is to fall victim to the ancient fallacy of *post hoc, ergo propter hoc.* The mere fact that two things happen concurrently is not adequate reason to believe that one is the effect of the other.

The improvement, as a matter of fact, has not been proportionally as great as in the United States, where freedom in the practice of medicine still flourishes. The credit taken by the Socialist government ignores the medical fact that newer treatments and drugs have lowered the infant and maternal death rate all over the world, regardless of politics.

In America, one of the greatest advances in hospital procedure has been the discovery that the sooner most patients are back on their feet, the quicker and more complete their restoration to normal health. The average length of hospitalization for an American patient is six or seven days. In 2,400 hospitals of England and Wales, I found, the average stay is 20 days.

These differences between the situation here and that which obtained in another country must be taken into account lest we somehow find ourselves the owners of an odious solution for problems we do not have. Ours is not a problem of finding something —almost anything—to make a broken-down mechanism function somehow. We do need to improve a mechanism which is already functioning well, although not perfectly. What we want is not something passable to replace something bad, but something better to replace something good. We need to develop a nation-wide, comprehensive, coordinated system of health insurance at a cost the public can afford. We need to do this without making physicians and surgeons and men and women qualified and trained to medical and hospital service a cat's paw of politics.

American doctors have not been caught napping. They are organized for action—not as just another pressure group motivated by self-interest, but as those best qualified to examine the problem in all its complexity and inform and advise the public in the promotion of a program neither hasty nor makeshift nor doctrinaire, but wise and considered and constructive, to bring better medical care to more people.

Everywhere I went in England I heard from every side the statement: "You are merely ten years behind us; you will come to the same thing eventually." Will we? That depends on whether political medicine is an irresistible trend or the result of specific conditions local to time and place.

From England I returned with this strong conviction: If we are to preserve the free enterprise system which has made America the greatest nation in the world, medicine's special task in the struggle to do so is a concerted effort to broaden the scope of good medical and hospital insurance plans.

The private practice of medicine and the voluntary hospital system are living expressions of the free enterprise system. If they fail to grow and hold the confidence of the people, the clammy hand of Statism, Socialism and Communism will crush to earth the finest medical and hospital system in the world.

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